July 27, 2004

Trustmark Insurance Company Medical Questionnaire
PO Box 7930, Lake Forest, IL. 60045
Phone (800) 229-4543 Fax (847) 615-4954

CYST QUESTIONNAIRE

Proposed Insured: Birthdate:
Address: Employee:
Employer:
Home Phone: Cert.#:
Work Phone:

1. Name, address and phone number of your doctor:________________________________

   ____

2. Date last seen prior to application sign date:__________________________________
3. Current height and weight: ____
4. List all medications you are currently taking: ____________________________________

   ____

5. List all conditions for which you are currently seeing a doctor:______________________

   ____

6. Was the cyst surgically removed? Provide date and details:________________________

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7. Was there any evidence of malignancy?_____________________________________
8. Where was the cyst located and have there been any reoccurrence?__________________
9. Are you receiving any other type of treatment for the cyst?________________________

   ____

10. Are you fully recovered?____

______________________________ ______________________
Signature of Proposed Insured Date

DUE DATE: